

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/19/03.

I. DISPUTE

Whether there should be additional reimbursement for date of service 9/10/03. The Carrier denied additional reimbursement for CPT code E1399 Water Circulating Pad as “U X375 – Unnecessary medical treatment of service.” CPT code L3670 Post-Op Fracture Brace (Ultrasling II) was denied as “F Z560 – The charge for this procedure exceeds the fee schedule or usual and customary values established by Ingenix.”

II. FINDINGS

On 2/02/04, the Requestor submitted a withdrawal letter for date of service 9/10/03, HCPCS code E1399 Water Circulating Pad denied as unnecessary medical treatment of service. On 2/03/04, a Notice was faxed to the Requestor to submit additional documentation necessary to support the fee charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the requestor’s receipt of this Notice.

III. RATIONALE

HCPCS Code L3670 Post-Op Fracture Brace (Ultrasling II)

The Requestor billed \$450.00 for DME. The Carrier reimbursed \$108.10 leaving \$341.90 in dispute. The MFG DME GR (IX)(C) states, “...Invoices shall be billed at the provider’s usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and the carrier or if there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set forth for the “D” codes in the 1991 Medical Fee Guideline.” There is no “D” code listed for this DME.

Texas Labor Code 408.027 (c), Commission Rule 133.304 (i) (1-4) and 133.307 (j) (1) (F) places certain requirements on the Carrier when reducing the billed amount to fair and reasonable. The Respondent has not supported their rate of reimbursement as fair and reasonable.

Per Rule 133.307 (g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The additional documentation submitted by the Requestor included the prescription and a letter of medical necessity. However, the Requestor failed to submit documentation to sufficiently justify that the Respondent’s reimbursement was not fair and reasonable or inconsistent with Sec. 413.011 (d) of the Texas Labor Code. Therefore, no additional reimbursement is recommended.

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the Requestor **is not** entitled to reimbursement for CPT code L3670.

The above Findings and Decision is hereby issued this 07th day of June 2004.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd